PREPARTICIPATION PHYSICAL EVALUATION
HEALTH HISTORY QUESTIONNAIRE

Date:_____

Name: _____ **Date of Last Physical:** _____ **Age:** _____
Date of Birth: _____ **School:** _____ **Sex:** _____
Sport: _____ **Home Phone:** _____ **Grade:** _____
Physician: _____ **Phone:** _____ **Fax:** _____

Emergency Contact Information:
Name:_____**Relationship:** _____**Phone (Circle One): Cell/Home/Work** _____

Directions: Please answer the following questions about your medical history. Explain "yes" answers at the bottom of the page. You must respond to all questions.

1. Have you had or do you currently have:

a. A sports physical for this school year?	**Y / N / Don't Know**
b. An injury or illness since your last exam?	**Y / N / Don't Know**
c. A chronic or ongoing illness (such as diabetes or asthma)?	**Y / N / Don't Know**
1. Use an inhaler or other prescription medicine to control asthma?	**Y / N / Don't Know**
d. Any prescribed or over-the-counter medications that you take on a regular basis?	**Y / N / Don't Know**
e. Surgery, hospitalization or any emergency room visit(s)?	**Y / N / Don't Know**
f. Any allergies to medications?	**Y / N / Don't Know**
g. Any allergies to bee stings, pollen, latex or foods?	**Y / N / Don't Know**
1. Type of reaction: rash, hives, or skin condition?	**Y / N / Don't Know**
2. Take any medication/epipen taken for allergy symptoms? (List below)	**Y / N / Don't Know**
h. Any anemia or blood disorders?	**Y / N / Don't Know**

2. Have you had or do you currently have any of the following *head-related* conditions since your last physical:

a. Concussion requiring a physician's evaluation?	**Y / N / Don't Know**
1. How often and when? (answer below)	
b. Memory loss or been knocked out?	**Y / N / Don't Know**
c. A seizure?	**Y / N / Don't Know**
d. Frequent or severe headaches?	**Y / N / Don't Know**

3. Have you had or do you currently have any of the following *heart-related* conditions since your last physical:

a. Chest Pain? (when exercising?)	**Y / N / Don't Know**
b. Heart murmur?	**Y / N / Don't Know**
c. High blood pressure or elevated cholesterol level?	**Y / N / Don't Know**
d. Restriction from sports for heart problems?	**Y / N / Don't Know**
e. Any family member or relative:	
1. Died of a heart problem before age 35?	**Y / N / Don't Know**
2. Died of a heart problem before age 50?	**Y / N / Don't Know**
3. Died with no known reason?	**Y / N / Don't Know**
4 Died while exercising? During or after?	**Y / N / Don't Know**
5. Had Marfan's Syndrome?	**Y / N / Don't Know**

Explain "Yes" Answers Here (Include Dates):

_____
_____
_____
_____
_____

Continued on back of page

4. Have you had or do you currently have any of the following *eye, ear, nose, mouth or throat conditions* since your last physical:

a. Vision problems?	**Y / N / Don't Know**
1. Wear contacts, eyeglasses or protective eye wear? (Circle which type)	**Y / N / Don't Know**
b. Hearing loss or problems?	**Y / N / Don't Know**
1. Wear hearing aides or implants?	**Y / N / Don't Know**
c. Nasal fractures or frequent nose bleeds?	**Y / N / Don't Know**
d. Wear braces, retainer or protective mouth gear?	**Y / N / Don't Know**
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?	**Y / N / Don't Know**

5. Have you had or do you currently have any of the following *neuromuscular/orthopedic conditions* since your last physical:

a. Been told you had a burner, stinger or pinched nerve?	**Y / N / Don't Know**
b. A sprain	**Y / N / Don't Know**
c. A strain	**Y / N / Don't Know**
d. Swelling or pain in muscles, tendons, bones or joints?	**Y / N / Don't Know**
e. A dislocated joint(s)?	**Y / N / Don't Know**
f. Low back pain?	**Y / N / Don't Know**
g. Fracture(s) or stress fracture(s)?	**Y / N / Don't Know**
h. Do you wear any protective braces or equipment for any prior injury?	**Y / N / Don't Know**

6. Have you had or do you currently have any of the following *general or exercise-related conditions* since your last physical:

a. Difficulty breathing? (during exercise)	**Y / N / Don't Know**
1. After running 1 mile	**Y / N / Don't Know**
2. Coughing, wheezing or shortness of breath in weather changes?	**Y / N / Don't Know**
3. Been told you have exercise-induced asthma	**Y / N / Don't Know**
i. Controlled with medication? (List below)	**Y / N / Don't Know**
ii. Experience dizziness, passing out or fainting?	**Y / N / Don't Know**
b. Viral infections (e.g. mono, hepatitis)?	**Y / N / Don't Know**
c. Become tired more quickly than your friends?	**Y / N / Don't Know**
d. Any of the following skin conditions:	
1. Acne, contact dermatitis, ringworm, warts, herpes?	**Y / N / Don't Know**
2. Sun sensitivity?	**Y / N / Don't Know**
e. Weight gain/loss (greater than or less than 10 pounds)?	**Y / N / Don't Know**
1. Do you want to weigh more or less than you do now?	**Y / N / Don't Know**
f. Ever had feelings of depression?	**Y / N / Don't Know**
g. Heat-related problems (dehydration, dizziness, fatigue, headache)?	**Y / N / Don't Know**
1. Heat exhaustion? (cool, clammy, damp skin)	**Y / N / Don't Know**
2. Heat stroke? (hot, red, dry skin)	**Y / N / Don't Know**

Explain "Yes" Answers Here (Include Dates):

_____
_____
_____
_____
_____

I certify that the information provided herein is accurate as of the date of these signatures.

Parent/Guardian Signature:_____ **Date:**_____
Student Signature:_____ **Date:**_____

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